

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-033895**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **43**

Primary Registration District No. **2007**

Registrar's No. **1033**

**FILED OCT 9 1962**

VS 300  
Rev. 4/59

**1 0128**

**2 1035**

**3**

**4 0**

**5 1**

**6**

**7 1**

**8 0**

**9 332X**

**10**

**11**

**12 2-0**

**13 1-0**

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		c. CITY OR TOWN <b>Dexter</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Doctor's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>9 South Hickory</b>	
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>W.</b> Last <b>Farmer</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>4,</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-1909</b>
9. AGE (last birthday) <b>53</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>13</b>	
11. IF UNDER 24 HR Hours <b></b> Min. <b></b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <b>Milan, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Will Farmer</b>		13b. MOTHER'S MAIDEN NAME <b>Leila Dugger</b>	
14. NAME OF HUSBAND OR WIFE <b>Leacy Farmer</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Mrs. Leacy Farmer, Dexter, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>	Month, Day, Year <b></b>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>9-19-62</b> to <b>10-4-62</b> and last saw her/him alive on <b>10-4-62</b> Death occurred at <b>1:40 P. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>David V. Miller M.D.</b>	
22b. ADDRESS <b>Poplar Bluff, Mo.</b>		22c. DATE SIGNED <b>10-4-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-6-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Milan</b>	23d. LOCATION (City, town, or county) (State) <b>Milan, Tenn.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Rainey Funeral Home, Dexter, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-6-1962</b>	26. REGISTRAR'S SIGNATURE <b>Thelma Graham</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

APR 23 1963

OCT 16 1962

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lucille Purney

Licensed Embalmer No. 4983

P. O. Address Dexter, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.